SENATE HEALTH AND WELFARE

ADMINISTRATIVE RULES REVIEW

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2006 Legislative Session

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0601

NOTICE OF RULEMAKING - TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2006.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than January 18, 2006.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Beginning January 1, 2006, Medicaid recipients who are also on Medicare will no longer have their prescriptions paid for by Idaho's Medicaid Program. They will be covered by the new Medicare Prescription Drug Plan. Under the new drug plan, Medicaid recipients on Medicare will have out of pocket costs of $1 or $3 for each prescription and may also have an additional cost for the monthly premium of their chosen drug plan. The increase in the basic allowance assists this population by providing additional money for the Medicaid recipient so it can be used on their increased out of pocket medical costs. The rule changes will increase the individual's basic allowance from $67 a month to $87 a month in the following living arrangements: Room and Board Home, Residential and Assisted Living Facilities (RALF), and Certified Family Homes (CFH).

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(a) and (b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: This rulemaking is being promulgated for protection of the public health, safety and welfare; and also confers a benefit.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: NA - There is no fee attached to this rulemaking. The $1 to $3 out of pocket costs is for Medicare, not Medicaid.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. There is no fiscal impact to the state general fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule confers a benefit to participants and no objections to the rule are expected.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Peggy Cook at (208) 334-5969.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before January 25, 2006.

DATED this 15th day of November, 2005.

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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

501. BASIC ALLOWANCE.
Each participant receives a basic allowance unless he lives in a nursing facility. The basic allowance for each living arrangement is listed in Subsections 501.01 through 501.05. The Semi-Independent Group Residential Facility, Room and Board, Residential and Assisted Living Facility and Certified Family Home basic allowances are those in effect January 1, 2001. They do not change with the annual cost-of-living increase in the federal SSI benefit amount. (5-3-03)

01. Single Participant. Through December 31, 2000, a participant is budgeted five hundred forty-five dollars ($545) monthly as a basic allowance when living in a situation described in Subsections 501.01.a. through 501.01.e. Beginning January 1, 2001, the basic allowance increase for a single participant is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. (3-30-01)

a. Living alone. (7-1-99)

b. Living with his ineligible spouse. (7-1-99)

c. Living with another participant who is not his spouse. (7-1-99)

d. Living in another's household. This includes a living arrangement where the participant purchases lodging (room) and meals (board) from his parent, child or sibling. (3-30-01)

e. Living with his TAFI child. (7-1-99)

02. Couple or Participant Living With Essential Person. Through December 31, 2000, a participant living with his participant spouse or his essential person is budgeted seven hundred sixty-eight dollars ($768) monthly as a basic allowance. Beginning January 1, 2001, the basic allowance increase for a couple is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a couple. The increase may be rounded up. (3-30-01)

03. SIGRIF. A participant living in a semi-independent group residential facility (SIGRIF) is budgeted three hundred forty-nine dollars ($349) monthly as a basic allowance. (7-1-99)

04. Room and Board Home. A participant living in a room and board home, as defined in Section 512, is budgeted ~~*sixty*~~ eighty-seven dollars ($~~6~~87) monthly as a basic allowance. ~~*(3-15-02)*~~(1-1-06)T

05. Personal Care Supplement. A participant living in a Residential and Assisted Living Facility, or Certified Family Home with state plan personal care services, is budgeted five hundred and twenty dollars ($520) monthly as a Basic Allowance, if he does not have enough income to pay his provider for his rent, utilities and food. To receive a Personal Care Supplement, the participant's income after exclusions and disregards must be less than his Basic Allowance. Beginning January 1, 2003, the basic allowance increase is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. (5-3-03)

(BREAK IN CONTINUITY OF SECTIONS)

512. ROOM AND BOARD HOME ALLOWANCE.
Room and board is a living arrangement where the participant purchases lodging (room) and meals (board) from a person he lives with who is not his parent, child or sibling. ~~*Through December 31, 2000, a participant living in a room and board home is budgeted six hundred thirty-two dollars ($632) monthly. Beginning January 1, 2001, the Room and Board allowance increase is one-half (1/2) the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. Beginning January 1, 2002, the Room and Board allowance increase is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person.*~~ Beginning January 1, 2006, a participant living in a room and board home is budgeted six hundred ninety-three dollars ($693). Beginning January 1, 2007, the Room and Board allowance increase is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. ~~*(3-20-04)*~~(1-1-06)T

513. LICENSED RESIDENTIAL AND ASSISTED LIVING FACILITY AND CERTIFIED FAMILY HOME ALLOWANCES.
A participant living in a Residential and Assisted Living Facility (RALF), (~~*see*~~ in accordance with

IDAPA 16.03.22, "Rules Governing Licensed Residential and Assisted Living Facilities in Idaho") or Certified Family Home (CFH), (~~*see*~~ in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes") with State Plan Personal Care Services, is budgeted a basic allowance of ~~*sixty*~~ eighty-seven dollars ($~~6~~87) monthly. A participant is also budgeted a monthly allowance for care based on his level of care. If the participant gets a lower level of RALF or CFH care than his assessed level, his allowance is for the lower level of care. These allowances are used to determine eligibility for Medicaid. ~~*The participant is not entitled to AABD cash assistance, unless he*~~ These allowances are only used for AABD cash when the participant is entitled to the ~~*Personal Care Supplement in Subsection 512.05 of these rules*~~ DD Waiver in accordance with Section 789, "Developmentally Disabled (DD) Waiver," of this rule. If the participant does not require the RALF or CFH level of care, his eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. ~~*A participant with Home and Community-Based Services for the aged and disabled (HCBS-A&D) is not entitled to cash assistance.*~~ ~~*(5-3-03)*~~(1-1-06)T

01. Care Levels and Monthly Allowances. ~~*Through December 31, 2000*~~ Beginning January 1, 2006, care levels and monthly allowances are those listed in Table 513. ~~*Beginning January 1, 2001, through December 31, 2001, the RALF and CFH care allowances and the basic allowance increase by one-half (1/2) the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person.*~~ Beginning January 1, 200~~2~~7, the RALF and CFH allowances increase by the full dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person.

TABLE 513 - CARE LEVELS AND ALLOWANCES AS OF 1~~2-3~~1-0~~0~~6

	Level Of Care	Monthly Allowance
a.	Level I	~~*Seven*~~ Eight hundred and ~~*seventy-four*~~ thirty-five dollars ($~~*774*~~835)
b.	Level II	~~*Eight*~~ Nine hundred and ~~*forty-one*~~ two dollars ($~~*841*~~902)
c.	Level III	Nine hundred and sixty-nine dollars ($9~~0~~69)

~~*(3-15-02)*~~(1-1-06)T

02. CFH Operated by Relative. A participant living in a Certified Family Home (CFH) operated by his parent, child or sibling is not entitled to the CFH allowances. He may receive the allowance for a person living with a relative. A relative for this purpose is the participant's parent, child, sibling, aunt, uncle, cousin, niece, nephew, grandparent or grandchild by birth, marriage, or adoption. (3-15-02)

IDPAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0506

NOTICE OF RULEMAKING - TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is April 7, 2005.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code, and House Bill 324 (2005).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than Wednesday, December 21, 2005.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

To better protect the health and safety of Idahoans, these rules are being amended to allow for Medicaid coverage of investigational medical treatments and procedures when the medical review process indicates that such a procedure is necessary and would benefit the health of the participant. The rule changes also provide operational definitions of what constitutes an investigational or experimental service or procedure to comply with House Bill 324 (2005) that prohibits Medicaid coverage of experimental medical services or procedures. Outdated language was also updated to meet currently accepted standards. These proposed rule changes:

1. Identify the review and analysis required to determine coverage for investigational services or procedures;
2. Add a definition of experimental services or procedures;
3. Update the current standards for the coverage of weight loss surgery and clarify coverage of non-surgical options for the treatment of obesity; and
4. Clarify the coverage limitations for organ transplants.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate since it is necessary for the protection of the public health, safety, or welfare.

FEE SUMMARY: There is no fee or charge being imposed or increased in this docket.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

This rule does not result in any additional costs to the Medical Assistance program as the changes proposed do not expand upon existing coverage; rather, they clarify how coverage determinations are made so that decisions will be cost effective and not arbitrary.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this change was made to reflect internal Medicaid policy decisions and to comply with House Bill 324 (2005).

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Leslie Clement at (208) 364-1804.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, December 28, 2005.

DATED this 2nd day of November, 2005.

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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

061. -- 064~~3~~. (RESERVED).

064. COVERAGE OF INVESTIGATIONAL PROCEDURES OR TREATMENTS.
The Department may consider Medicaid coverage for investigational procedures or treatments on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available. For these cases, a focused case review is completed by a professional medical review organization to determine if an investigational procedure would be beneficial to the participant. The Department will perform a cost/benefit analysis on the procedure or treatment in question. The Department will determine coverage based on this review and analysis. (4-7-05)T

01. Focused Case Review. A focused case review consists of assessment of the following: (4-7-05)T

a. Health benefit to the participant of the proposed procedure or treatment; (4-7-05)T

b. Risk to the participant associated with the proposed procedure or treatment; (4-7-05)T

c. Result of standard treatment for the participant's condition, including alternative treatments other than the requested procedure or treatment; (4-7-05)T

d. Specific inclusion or exclusion by Medicare national coverage guidelines of the proposed procedure or treatment; (4-7-05)T

e. Phase of the clinical trial of the proposed procedure or treatment; (4-7-05)T

f. Guidance regarding the proposed procedure or treatment by national organizations; (4-7-05)T

g. Clinical data and peer-reviewed literature pertaining to the proposed procedure or treatment; and (4-7-05)T

h. Ethics Committee review, if appropriate. (4-7-05)T

02. Additional Clinical Information. For cases in which the Department determines that there is insufficient information from the focused case review to render a coverage decision, the Department may, at its discretion, seek an independent professional opinion. (4-7-05)T

03. Cost/Benefit Analysis. The Department will perform a cost/benefit analysis that will include at least the following: (4-7-05)T

a. Estimated costs of the procedure or treatment in question. (4-7-05)T

b. Estimated long-term medical costs if this procedure or treatment is allowed. (4-7-05)T

c. Estimated long-term medical costs if this procedure is not allowed. (4-7-05)T

d. Potential long-term impacts approval of this procedure or treatment may have on the medical assistance program. (4-7-05)T

04. Coverage Determination. The Department will make a decision about coverage of the investigational procedure or treatment after consideration of the focused case review, cost/benefit analysis, and any additional information received during the review process. (4-7-05)T

065. SERVICES, TREATMENTS, AND PROCEDURES NOT COVERED BY MEDICAL ASSISTANCE.
The following services, treatments, and procedures are not covered for payment by the Medical Assistance Program: ~~*(5-15-84)*~~(4-7-05)T

01. Service Categories ~~*Excluded*~~ Not Covered. The following ~~*categories of*~~ service categories are ~~*excluded from MA*~~ not covered for payment by the Medical Assistance Program:

~~*(5-15-84)*~~(4-7-05)T

a. Acupuncture services; ~~*and*~~ ~~*(5-15-84)*~~(4-7-05)T

b. Naturopathic services; ~~*and*~~ ~~*(5-15-84)*~~(4-7-05)T

c. Bio-feedback therapy; and (11-10-87)

d. Fertility-related services, including testing. ~~*(11-10-87)*~~(4-7-05)T

02. ~~***Procedures Excluded***~~ **Types of Treatments and Procedures Not Covered**. The costs of physician and hospital services for the following types of treatments and procedures are ~~*excluded from MA payment. This includes both the procedure itself, and the costs for all follow-up medical treatment directly associated with such a procedure*~~ not covered for payment by the Medical Assistance Program: ~~*(6-1-86)*~~(4-7-05)T

a. Elective medical and surgical treatment, except for family planning services, without Departmental approval. Procedures that are generally accepted by the medical community and are medically necessary may not require prior approval and may be eligible for payment; ~~*or*~~ ~~*(6-1-86)*~~(4-7-05)T

b. Cosmetic surgery, excluding reconstructive surgery ~~*which*~~ that has prior approval by the Department; ~~*or*~~ ~~*(7-1-98)*~~(4-7-05)T

c. Acupuncture; ~~*or*~~ ~~*(6-1-86)*~~(4-7-05)T

d. Bio-feedback therapy; ~~*or*~~ ~~*(6-1-86)*~~(4-7-05)T

e. Laetrile therapy; ~~*or*~~ ~~*(6-1-86)*~~(4-7-05)T

~~***f.*** *Organ transplants; lung, pancreas, or other transplants considered investigative or experimental procedures and multiple organ transplants; or* *(10-1-91)*~~

~~***g***~~**f.** Procedures and testing for the inducement of fertility. This includes, but is not limited to, artificial inseminations, consultations, counseling, office exams, tuboplasties, and vasovasostomics~~.~~; ~~*(11-10-87)*~~(4-7-05)T

~~***h***~~**g.** New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and ~~*which*~~ that are excluded by the Medicare program ~~*are excluded from MA payment*~~ or major commercial carriers; ~~*or*~~ ~~*(5-15-84)*~~(4-7-05)T

~~***i***~~**h.** Drugs supplied to patients for self-administration other than those allowed under the conditions of Section ~~*126*~~ 805; ~~*or*~~ ~~*(12-31-91)*~~(4-7-05)T

~~***j***~~**i.** Examinations: (6-1-86)

i. For routine checkups, other than those associated with the EPSDT program; ~~*or*~~ ~~*(6-1-86)*~~(4-7-05)T

ii. In connection with the attendance, participation, enrollment, or accomplishment of a program; or (6-1-86)

iii. For employment. (6-1-86)

~~*k*~~**j.** Services provided by psychologists and social workers who are employees or contract agents of a physician, or a physician's group practice association except for psychological testing on the order of the physician; ~~*or*~~ ~~*(6-1-86)*~~(4-7-05)T

~~*l*~~**k.** The treatment of complications, consequences, or repair of any medical procedure~~, *in which*~~ where the original procedure was ~~*excluded from MA coverage*~~ not covered by the Medical Assistance Program, unless the resultant condition is life-threatening as determined by the ~~*MA Section of the*~~ Department; ~~*or*~~ ~~*(5-15-84)*~~(4-7-05)T

~~*m*~~**l.** Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service ~~*are excluded from MA payment.*~~; ~~*(5-15-84)*~~(4-7-05)T

~~*n*~~**m.** Eye exercise therapy~~.~~; or ~~*(10-25-88)*~~(4-7-05)T

~~*o*~~**n.** Surgical procedures on the cornea for myopia. (3-2-94)

03. Experimental Treatments or Procedures. Treatments and procedures used solely to gain further evidence or knowledge or to test the usefulness of a drug or type of therapy are not covered for payment by the Medical Assistance Program. This includes both the treatment or procedure itself, and the costs for all follow-up medical treatment directly associated with such a procedure. Treatments and procedures deemed experimental are not covered for payment by the Medical Assistance Program under the following circumstances: (4-7-05)T

a. The treatment or procedure is in Phase I clinical trials in which the study drug or treatment is given to a small group of people for the first time to evaluate its safety, determine a safe dosage range, and identify side effects; (4-7-05)T

b. There is inadequate available clinical or pre-clinical data to provide a reasonable expectation that the trial treatment or procedure will be at least as effective as non-investigational therapy; or (4-7-05)T

c. Expert opinion suggests that additional information is needed to assess the safety or efficacy of the proposed treatment or procedure. (4-7-05)T

(BREAK IN CONTINUITY OF SECTIONS)

069. SURGICAL PROCEDURES FOR WEIGHT LOSS.

01. Surgery for the Correction of Obesity. Surgery for the correction of obesity is covered ~~*only with prior authorization from the Bureau of Medicaid Policy and Reimbursement. Surgical procedures for weight loss will be considered when the patient meets the weight criteria for morbid obesity as defined in Subsection 003.38 of these rules; and*~~ when all of the following conditions are met: ~~*(7-1-99)*~~(4-7-05)T

a. ~~*Has one (1) of the major life threatening complications of obesity: alveolar hypoventilation, uncontrolled diabetes, or uncontrolled hypertension:*~~ The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than forty (40), or a BMI equal to or greater than thirty-five (35) with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities. The serious comorbid medical condition must be documented by the primary physician who refers the patient for the procedure, or a physician specializing in the participant's comorbid condition who is not associated by clinic or other affiliation with the surgeons who will perform the surgery. ~~*(7-1-97)*~~(4-7-05)T

~~*i. For purposes of this Subsection, "uncontrolled" means that there is inadequate compliance or response to a prescribed medical regimen. (7-1-97)*~~

~~*ii. Other complications of obesity such as orthopedic treatment, skin and wound care are not considered justification for a surgical remedy. (7-1-97)*~~

b. ~~*Must have a psychiatric evaluation to determine the stability of personality at least three (3) months prior to date the surgery is requested;*~~ The obesity is caused by the serious comorbid condition, or the obesity could aggravate the participant's cardiac, respiratory or other systemic disease. ~~*(7-1-97)*~~(4-7-05)T

c. ~~*Understands and accepts the resulting risks associated with the surgery.*~~ The Department or its designee must determine the surgery to be medically necessary, as defined in Section 003 of these rules. ~~*(7-1-97)*~~(4-7-05)T

d. The participant must have a psychiatric evaluation to determine the stability of personality at least ninety (90) days prior to the date a request for prior authorization is submitted to Medicaid. (4-7-05)T

e. The surgery must be prior authorized by the Department or its designee. The Department will consider the guidelines of private and public payors, evidence-based national standards of medical practice, and the medical necessity of each participant's case when determining whether surgical correction of obesity will be prior authorized. (4-7-05)T

02. ~~*All Patients Requesting Surgery*~~ Non-Surgical Treatment for Obesity. ~~*All patients requesting surgery must have their physician send a complete history and physical exam, and medical records documenting the patient's weight and efforts to lose weight by conventional means over the past five (5) years for the request to be considered.*~~ Services in connection with non-surgical treatment of obesity are covered only when such services are an integral and

necessary part of treatment for another medical condition that is covered by Medicaid.
~~*(7-1-97)*~~(4-7-05)T

~~***03. The Documentation of Life-Threatening Complications****. The documentation of life-threatening complications in Subsection 069.01.c. of these rules. must be provided by a consultant specializing in pulmonary diseases, endocrinology, or cardiology/hypertensive illness who is not associated by clinic or other affiliation with the surgeons who will perform the surgery, or the primary physician who refers the patient for the procedure.*** ~~*(7-1-97)*~~

04<u>3</u>. Abdominoplasty or Panniculectomy. Abdominoplasty or panniculectomy is covered ~~*only with prior authorization from the Bureau of Medicaid Policy and Reimbursement. Medicaid does not cover procedures for cosmetic purposes*~~ when medically necessary, as defined in Section 003 of these rules, and when the surgery is prior authorized by the Department or its designee. The ~~*documentation that must accompany a*~~ request for prior authorization must include~~*s, but is not limited to,*~~ the following documentation:
~~*(7-1-97)*~~(4-7-05)T

a. Photographs of the front, side and underside of the ~~*patient's*~~ participant's abdomen; ~~*and*~~
~~*(7-1-97)*~~(4-7-05)T

b. ~~*Documented t*~~Treatment of ~~*the*~~ any ulceration and skin infections involving the panniculus; ~~*and*~~
~~*(7-1-97)*~~(4-7-05)T

c. ~~*Documented f*~~Failure of conservative treatment, including weight loss; ~~*and*~~
~~*(7-1-97)*~~(4-7-05)T

d. That the panniculus severely inhibits the ~~*patient's*~~ participant's walking; ~~*and*~~
~~*(7-1-97)*~~(4-7-05)T

e. That ~~*T*~~the ~~*client*~~ participant is unable to wear a garment to hold the panniculus up; and
~~*(7-1-97)*~~(4-7-05)T

f. Other detrimental effects of the panniculus on the ~~*patient's*~~ participant's health such as severe arthritis in the lower body.
~~*(7-1-97)*~~(4-7-05)T

(BREAK IN CONTINUITY OF SECTIONS)

081. ORGAN TRANSPLANTS.
The Department may ~~*purchase*~~ reimburse for organ transplant services for bone marrows, kidneys, hearts, intestines, and livers when provided by hospitals approved by the ~~*Health Care Financing Administration*~~ Centers for Medicare and Medicaid for the Medicare program ~~*and*~~ that have completed a provider agreement with the Department. The Department may ~~*purchase*~~ reimburse for cornea transplants for conditions where such transplants have demonstrated efficacy.
~~*(3-15-02)*~~(4-7-05)T

~~***01. Heart or Liver Transplants****. Heart or liver transplant surgery will be covered.*** ~~*(3-15-02)*~~

0~~2~~1. Kidney Transplants. Kidney transplant~~ation~~ surgery will be covered only in a renal transplantation facility participating in the Medicare program after meeting the criteria specified in 42 CFR 405 Subpart U. Facilities performing kidney transplants must belong to one (1) of the End Stage Renal Dialysis (ESRD) network area's organizations designated by the Secretary of Health and Human Services for Medicare certification. ~~*(10-1-91)*~~(4-7-05)T

0~~3~~2. Living Kidney Donor Costs. The transplant costs for actual or potential living kidney donors are fully covered by Medicaid and include all reasonable preparatory, operation, and post-operation recovery expenses associated with the donation. Payments for post-operation expenses of a donor will be limited to the period of actual recovery. (10-1-91)

0~~4~~3. Intestinal Transplants. Intestinal transplant~~ation~~ surgery will be covered only for patients with irreversible intestinal failure, and who have failed total parenteral nutrition. ~~*(3-15-02)*~~(4-7-05)T

0~~5~~4. Coverage Limitations. ~~*When the need for transplant of a second organ such as a heart, lung, liver, bone marrow, pancreas, or kidney represents the coexistence of significant disease, the organ transplants will not be covered.*~~ ~~*(10-1-91)*~~(4-7-05)T

a. Multi-organ transplants may be covered when: (4-7-05)T

i. The primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process; and (4-7-05)T

ii. The damage to the second organ will compromise the outcome of the transplant of the primary organ. (4-7-05)T

~~a~~b. Each kidney or lung is considered a single organ for transplant; (10-1-91)

~~b~~c. Retransplants will be covered only if the original transplant was performed for a covered condition and if the retransplant is performed in a Medicare/Medicaid approved facility; (10-1-91)

~~c~~d. A liver transplant from a live donor will not be covered by the Medical Assistance Program; ~~*(3-15-02)*~~(4-7-05)T

~~***d.*** *Multi-organ transplants such as heart/lung or kidney/pancreas and the transplant of artificial hearts or ventricular assist devices are not covered;* *(10-1-91)*~~

e. ~~*Except for cornea transplants, all*~~ No organ transplants ~~*are excluded from MA payment*~~ covered by the Medical Assistance Program unless prior ~~*pre*~~authorized by the Department or its designee, and performed for the treatment of medical conditions where such transplants have a demonstrated efficacy. ~~*(3-15-02)*~~(4-7-05)T

~~***06. Noncovered Transplants.*** *Services, supplies, or equipment directly related to a noncovered transplant will be the responsibility of the recipient.* *(10-1-91)*~~

0~~7~~5. Follow-Up Care. Follow-up care to a recipient who received a covered organ transplant may be provided by a Medicare/Medicaid participating hospital not approved for organ transplantation. (10-1-91)

HEALTH AND WELFARE

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0601

NOTICE OF RULEMAKING - TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is May 1, 2006.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Sections 56-202(b), and 56-203(g), Idaho Code, and HB385 passed by the 2005 Legislature.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

This rulemaking establishes a program that credentials mental health agencies to assure mental health clinics and psychosocial rehabilitation providers meet minimal quality standards, utilize qualified providers, and provide appropriate services that meet the needs of Medicaid participants. Under these rules, mental health agencies will be required to undergo a Department-approved credentialing process prior to being authorized to deliver and bill for services, and to be re-credentialed on a periodic basis.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: This rule protects the public health, safety, and welfare of Idahoans.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. HB385 passed by the 2005 Idaho Legislature appropriated Three hundred and fifty thousand dollars ($350,000) to the Department to contract with an outside vendor for a credentialing process.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Jamie Simpson at (208) 364-1842.

DATED this 9th day of November, 2005.

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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

449. DEFINITIONS FOR PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR).

01. Assessment Hours. Time allotted for completion of evaluation and diagnostic services. (4-6-05)

02. Credentialing. A process where the Medicaid PSR agency is approved by the Department or the Department's designee as having met the requirements of the provider agreement and professional standards defined in these rules. (5-1-06)T

0~~2~~3. Demographic Information. Information that identifies participants and is entered into the Department’s database collection system. (4-6-05)

0~~3~~4. Goal. The desired outcome related to an identified issue. (4-6-05)

0~~4~~5. Initial Contact. The date a participant, parent, or legal guardian signs the request for assessment hours. (4-6-05)

0~~5~~6. Issue. A statement specifically describing the participant's behavior directly relating to the participant's mental illness and functional impairment. (4-6-05)

0~~6~~7. Licensed Practitioner of the Healing Arts. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. The nurse practitioner and clinical nurse specialist must have experience prescribing psychotropic medication. (4-6-05)

0~~7~~8. Objective. A milestone toward meeting the goal that is concrete, measurable, time-limited, and behaviorally specific. (4-6-05)

0~~8~~9. Psychosocial Rehabilitative Services (PSR). Rehabilitative services provided both to children with serious emotional disturbance and to adults with severe and persistent mental illness to address functional deficits due to psychiatric illness and to restore independent living, socialization, and effective life management skills. (4-6-05)

***~~09~~*10. Tasks**. Specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

451. RESPONSIBILITIES OF THE DEPARTMENT REGARDING PSR SERVICES. The Department will administer the provider agreement for the provision of PSR services and is responsible for the following tasks: (4-6-05)

01. Service System. The Department is responsible for the development, maintenance and coordination of regional, comprehensive and integrated service systems. (4-6-05)

02. Credentialing. The Department is responsible for ensuring Medicaid PSR agencies meet credentialing requirements. (5-1-06)T

0~~2~~3. Assessment Authorization. The Department or its designee will review requests for assessment hours and authorize as appropriate. (4-6-05)

0~~3~~4. Individualized Treatment Plan Authorization Requirements. Individualized treatment plan authorizations must include the following: (4-6-05)

a. Required Documentation. The required documentation for each individualized treatment plan includes: (4-6-05)

i. Participant demographic information; (4-6-05)

ii. A comprehensive assessment as provided in Subsection 453.01 of these rules; and (4-6-05)

iii. A written individualized treatment plan as provided in Subsection 453.02 of these rules. (4-6-05)

iv. Adult service plans also require a rehabilitation outcome database. (4-6-05)

v. Children's individualized treatment plans also require the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). (4-6-05)

b. Physician's Signature and Receipt of Required Documentation. Reimbursement for services will be authorized from the date of the physician's signature if the required documentation is received by the Department or its designee within thirty (30) days from the request of assessment hours. If the documentation is received after thirty (30) days from the date of the request of assessment hours, or after the expiration of the plan, the date to begin services is the date the individualized treatment plan and other required documentation are received by the Department or its designee. For the annual update, all required documentation must be received by the Department or its designee before the expiration date of the current assessment and plan. In order for a prior authorization to remain valid throughout the treatment plan year, documentation of the one hundred twenty (120) day reviews must comply with Subsection 457.05 of these rules. (4-6-05)

c. Hours and Type of Service. The Department or its designee must authorize the number of hours and type of services which could be reasonably expected to lead to achievement of the individualized treatment plan objectives. (4-6-05)

d. Authorization Time Period. Service authorizations are limited to a twelve (12) month period and must be reviewed and updated at least annually. (4-6-05)

e. No Duplication of Services. The Department or its designee must monitor, coordinate, and jointly plan with all known providers to a participant to prevent duplication of services provided to PSR participants through other Medicaid reimbursable and non-Medicaid programs. (4-6-05)

04~~5~~5. Notice of Decision. At the point a decision is made that a participant is ineligible for PSR services, a notice of decision citing the reason(s) the participant is ineligible for PSR services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian. (4-6-05)

05~~5~~6. Changes in Individualized Treatment Plan Hours or Service Type. When the Department or its designee is notified, in writing, by the provider of recommended increases in hours or change in type of service provided, the Department or its designee must review the request and either approve or deny within ten (10) working days of receipt. A clear rationale for the change in hours or service type must be included with the request. (4-6-05)

06~~7~~7. Changes to Individualized Treatment Plan Objectives. When a provider believes that an individualized treatment plan needs to be revised, the provider should include that recommendation and rationale in documentation of the next one hundred twenty (120) day review. The Department or its designee will review the information, and if appropriate, act on the recommendation. In the event substantial changes in the participant's mental status or circumstances occur requiring immediate changes in the plan objectives, the provider must notify the Department or its designee, in writing, of its recommendation and rationale for the change. The Department has ten (10) working days to respond to and either approve or deny the request for change. (4-6-05)

07~~8~~8. Minor Changes to Individualized Treatment Plan Tasks. When the Department or its designee is notified in writing by the provider of necessary and specific changes to individualized treatment plan tasks that require no change in total hours or service type, a copy of the amended individualized treatment plan tasks must be forwarded to the Department or its designee including rationale for those changes. The Department or its designee has ten (10) working days to respond to the changes. If no response is received, the provider may proceed to incorporate those and only those specific task changes into the individualized treatment plan. While task changes may result in reassignment of available hours among tasks, under no circumstances does this permit the provider to increase the total number of prior authorized hours. (4-6-05)

08~~9~~9. Quality of Services. The Department or its designee must monitor the quality and

outcomes of PSR services provided to participants, in coordination with the Divisions of Medicaid, Management Services, and Family and Community Services. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

455. PSR PROVIDER AGENCY REQUIREMENTS.
Each agency that enters into a provider agreement with the Department for the provision of PSR services must meet the following requirements: (4-6-05)

01. Agency. A PSR agency must be a proprietorship, partnership, corporation, or other entity, employing at least two (2) staff qualified to deliver PSR services under Section 456 of these rules, and offering both PSR services and administrative services. Administrative services may include such activities as billing, hiring staff, assuring staff qualifications are met and maintained, setting policy and procedure, payroll. (4-6-05)

02. Credentialing. The Department is phasing in the Credentialing Program in 2006. During the first three (3) years of development the following will take place. (5-1-06)T

a. Reimbursement. A PSR agency must be designated as credentialed or provisionally credentialed in order to receive Medicaid reimbursement for services. Any agency that fails to maintain credentialed status will have its Medicaid provider agreement terminated. (5-1-06)T

b. Application. All existing providers and new provider applicants must submit an application for credentialing that will be reviewed in order to proceed with the credentialing process and obtain the required credential by the Department or its designee. All initial applications will be responded to within thirty (30) days indicating if the application is approved or additional information is required. The applicant must submit the additional information for the application to be considered further. The application will be reviewed up to three (3) times. If the applicant has not provided the required information by the third submittal then the application will be denied and the application will not be considered again for twelve (12) months. (5-1-06)T

c. Temporary Credentialed Status. In order for existing providers to be able to continue to provide services during these first three (3) years the Department will grant a one-time temporary credential to all existing providers not to exceed three (3) years. (5-1-06)T

d. New Providers. Once the Credentialing Program is initiated any new provider applicants will be required to submit an application and successfully complete the credentialing process prior to billing for Medicaid services. (5-1-06)T

e. Elements of Credentialing. The credentialing process consists of the application and an on-site review. Whenever deficiencies are identified a plan of improvement approved by the Department or its designee must be submitted by the agency. (5-1-06)T

f. Expiration and Renewal of Credentialed Status. Credentials issued under these

rules will be issued for a period up to three (3) years. Unless sooner suspended or revoked, the agency's credential will expire on the date designated by the Department or its designee. No later than ninety (90) days before expiration, an agency may apply for renewal of credentials. A site review may be conducted by the Department or its designee for renewal applications. (5-1-06)T

g. Provisional Credentialed Status. If a new or renewal applicant is found deficient in one (1) or more of the requirements for credentialing, but does not have deficiencies that jeopardize the health and safety of the participants or substantially affect the provider's ability to provide services, a provisional credential may be issued. Provisional credentials will be issued for a period not to exceed one hundred and eighty (180) days. During that time, the Department or its designee will determine whether the deficiencies have been corrected. If so, then the agency will be credentialed. If not, then the credential will be denied or revoked. (5-1-06)T

h. Denial, or Revocation of Credentialed Status. The Department or its designee may deny or revoke credentials when conditions exist that endanger the health, safety, or welfare of any participant or when the agency is not in substantial compliance with these rules. Additional causes for denial of credentials include the following: (5-1-06)T

i. The provider agency or provider agency applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining credentialed status; (5-1-06)T

ii. The provider agency or provider agency applicant has been convicted of a criminal offense related to the provider’s or applicant’s involvement in any program established under Medicare, Medicaid or the Title XX Services Program, or has been found to have committed any offense involving theft, or abuse, neglect or exploitation of another person; (5-1-06)T

iii. The provider agency or provider agency applicant has been convicted of a criminal offense within the past five (5) years, other than a minor traffic violation or similar minor offense; (5-1-06)T

iv. The provider agency or provider agency applicant has been denied or has had revoked any health facility license, or certificate; (5-1-06)T

v. A court has ordered that any provider agency owner or provider agency applicant must not operate a health facility, residential care or assisted living facility, or certified family home; (5-1-06)T

vi. Any owners, employees, or contractors of the provider agency or provider agency applicant are listed on the statewide Child Abuse Registry, Adult Protection Registry, Sexual Offender Registry, or Medicaid exclusion lists; (5-1-06)T

vii. The provider agency or provider agency applicant is directly under the control or influence, whether financial or other, of any person who is described in Subsections 455.02.h.i. through 455.02.h.vi. of these rules. (5-1-06)T

i. Procedure for Appeal of Denial or Revocation of Credentials. Immediately upon

denial or revocation of credentials, the Department or the Department's designee will notify the applicant or provider in writing by certified mail or by personal service of its decision, the reason for its decision, and how to appeal the decision. The appeal is subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings".
(5-1-06)T

0~~2~~3. Criminal History Checks. (4-6-05)

a. The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or PSR services have complied with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". (4-6-05)

b. Once an employee, subcontractor, or agent of the agency has completed a self-declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check. (4-6-05)

c. Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department or its designee when the agency learns of the conviction. (4-6-05)

0~~3~~4. PSR Agency Staff Qualifications. The agency must assure that each agency staff person delivering PSR services meets at least one (1) of the qualifications in Section 456 of these rules. (4-6-05)

~~***04. Supplemental Services Agreement.*** *The agency must have negotiated a Supplement Services Agreement (SSA) with the Department or its designee. The SSA must specify what PSR services must be provided by the agency. The agency's Supplemental Services Agreement must be reviewed at least annually and may be revised or cancelled at any time.*~~
~~*(4-6-05)*~~

05. Agency Employees and Subcontractors. Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency.
(4-6-05)

06. Supervision. The agency must provide staff with adequate supervision to insure that the tasks on a participant's individualized treatment plan can be implemented effectively in order for the individualized treatment plan objectives to be achieved. Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement. Individuals in Subsections 456.09 through 456.12 of these rules must be supervised by individuals in Subsections 456.01 through 456.08. Documentation of supervision must be maintained by the agency and be available for review by the Department or its designee. (4-6-05)

07. Continuing Education. The agency must assure that all staff complete twenty (20) hours of continuing education annually from the date of hire. Four (4) hours every four (4) years must be in ethics training. Staff who are not licensed must select the discipline closest to their own and use the continuing education standards attached to that professional license. Nothing in these rules will affect professional licensing continuing education standards and

requirements set by the Bureau of Occupational Licenses. (4-6-05)

08. Crisis Service Availability. PSR agencies must provide twenty-four (24) hour crisis response services for their participants or make contractual arrangement for the provision of those services. (4-6-05)

09. Ethics. (2-1-05)T

a. The provider must adopt, adhere to and enforce among its staff who are providing Medicaid reimbursable services a Code of Ethics similar to or patterned after one (1) of the following: (5-1-06)T

i. US Psychiatric Rehabilitation Association Code of Ethics found at http://www.uspra.org/i4a/pages/index.cfm?pageid=3601; (5-1-06)T

ii. National Association of Social Workers Code of Ethics found at http://www.naswdc.org/pubs/code/default.asp; (5-1-06)T

iii. American Psychological Association Code of Ethics found at http://www.apa.org/ethics/code.html; or (5-1-06)T

iv. American Counseling Association Code of Ethics found at http://www.counseling.org/Content/NavigationMenu/RESOURCES/ETHICS/ACA_Code_of_Ethics.htm (5-1-06)T

v. Marriage and Family Therapists Code of Ethics found at www.aamft.org/resources/lrmplan/ethics/ethicscode2001.asp. (5-1-06)T

b. Evidence of the Agency's Code of Ethics, the discipline(s) upon which it is modeled, and each staff member's training on the code must be submitted to the Department or its designee upon request. (5-1-06)T

c. The Provider must develop a schedule for providing ethics training to its staff. (5-1-06)T

d. The ethics training schedule must provide that new employees receive the training during their first year of employment, and that all staff receive ethics training no less than four hours every four (4) years thereafter. (5-1-06)T

460. BUILDING STANDARDS FOR PSR AGENCY LOCATIONS.

Each physical location that is maintained by the PSR agency and where participants go to meet or receive services must meet the following standards: (5-1-06)T

01. Accessibility. PSR service providers must be responsive to the needs of the service area and persons receiving services and accessible to persons with disabilities as defined in Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act, and the uniform federal accessibility standard. (5-1-06)T

02. **Environment**. PSR agency offices must be designed and equipped to meet the needs of each participant including, but not limited to, factors such as sufficient space, equipment, lighting and noise control. (5-1-06)T

03. **Capacity**. PSR agency offices must provide qualified staff as listed in Subsection 465.07 of these rules to meet a staff to participant ratio that ensures safe, effective and clinically appropriate interventions. (5-1-06)T

04. **Fire and Safety Standards**. (5-1-06)T

a. PSR agency offices must meet all local and state codes concerning fire and life safety. The owner/ operator must have the facility inspected at least annually by the local fire authority. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A copy of the inspection must be made available upon request and must include documentation of any necessary corrective action taken on violations cited; and (5-1-06)T

b. PSR agency offices must be structurally sound and must be maintained and equipped to assure the safety of participants, employees and the public; and (5-1-06)T

c. In PSR agency offices where natural or man-made hazards are present, suitable fences, guards or railings must be provided to protect participants; and (5-1-06)T

d. PSR agency offices must be kept free from the accumulation of weeds, trash and rubbish; and (5-1-06)T

e. Portable heating devices are prohibited except units that have heating elements that are limited to not more than 212°F. The use of unvented, fuel-fired heating devices of any kind are prohibited. All portable space heaters must be U.L. approved as well as approved by the local fire or building authority; and (5-1-06)T

f. Flammable or combustible materials must not be stored in the PSR agency; and (5-1-06)T

g. All hazardous or toxic substances must be properly labeled and stored under lock and key; and (5-1-06)T

h. Water temperatures in areas accessed by participants must not exceed 120°F; and (5-1-06)T

i. Portable fire extinguishers must be installed throughout the agency facility. Numbers, types and location must be directed by the applicable fire authority noted in Subsection 472.04 of these rules; and (5-1-06)T

j. Electrical installations and equipment must comply with all applicable local or state electrical requirements. In addition, equipment designed to be grounded must be maintained

in a grounded condition and extension cords and multiple electrical outlet adapters must not be utilized unless U.L. approved and the numbers, location, and use of them are approved, in writing, by the local fire or building authority. (5-1-06)T

k. There must be a telephone available on the premises for use in the event of an emergency. Emergency telephone numbers must be posted near the telephone or where they can be easily accessed; and (5-1-06)T

l. Furnishings, decorations or other objects must not obstruct exits or access to exits. (5-1-06)T

05. Emergency Plans and Training Requirements. (5-1-06)T

a. Evacuation plans must be posted throughout the facility. Plans must indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of building. (5-1-06)T

b. There must be written policies and procedures covering the protection of all persons in the event of fire or other emergencies; and (5-1-06)T

c. All employees must participate in fire and safety training upon employment and at least annually thereafter; and (5-1-06)T

d. All employees and PSR participants who receive services at that location must engage in quarterly fire drills. At least two (2) of these fire drills must include evacuation of the building; and (5-1-06)T

e. A brief summary of the fire drill and the response of the employees and participants must be written and maintained on file. The summary must indicate the date and time the drill occurred, problems encountered and corrective action taken. (5-1-06)T

06. Food Preparation and Storage. (5-1-06)T

a. If foods are prepared in the PSR agency offices, they must be stored in such a manner as to prevent contamination and be prepared by sanitary methods. (5-1-06)T

b. Except during actual preparation time, cold perishable foods must be stored and served under 45°F and hot perishable foods must be stored and served over 140°F. (5-1-06)T

c. Refrigerators and freezers used to store participant lunches and other perishable foods used by participants, must be equipped with a reliable, easily-readable thermometer. Refrigerators must be maintained at 45°F or below. Freezers must be maintained at 0°F to 10°F or below. (5-1-06)T

d. When meals are prepared or provided for by the PSR agency for participants, meals must be nutritional. (5-1-06)T

07. Housekeeping and Maintenance Services. (5-1-06)T

a. The interior and exterior of the PSR offices must be maintained in a clean, safe and orderly manner and must be kept in good repair; and (5-1-06)T

b. Deodorizers cannot be used to cover odors caused by poor housekeeping or unsanitary conditions; and (5-1-06)T

c. All housekeeping equipment must be in good repair and maintained in a clean, safe and sanitary manner; and (5-1-06)T

d. The PSR agency must be maintained free from infestations of insects, rodents and other pests; and (5-1-06)T

e. The PSR agency must maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means. (5-1-06)T

f. Garbage will be disposed of in a sanitary manner. It must not be allowed to accumulate and must be placed in leak-proof bags. (5-1-06)T

08. Firearms. No firearms are permitted in the PSR agency offices. (5-1-06)T

09. Plumbing. Restroom facilities must be maintained in good working order and available and accessible to participants while at the PSR agency offices in accordance with the Americans with Disabilities Act. This includes the presence of running water for operation of the toilet and washing hands. (5-1-06)T

10. Lighting. Lighting levels must be maintained throughout the PSR agency offices which are appropriate to the service being provided. (5-1-06)T

11. Drinking Water. Where the source is other than a public water system or commercially bottled, water quality must be tested and approved annually by the district health department. (5-1-06)T

46~~0~~1. CLINIC SERVICES - DIAGNOSTIC SCREENING CLINICS.
The Department will reimburse medical social service visits to clinics which coordinate the treatment between physicians and other medical professionals for recipients which are diagnosed with cerebral palsy, myelomeningitis or other neurological diseases and injuries with comparable outcomes. (4-1-91)

01. Multidisciplinary Assessments and Consultations. The clinic must perform on site multidisciplinary assessments and consul~~a~~tations with each recipient and responsible parent or guardian. Diagnostic and consultive services related to the diagnosis and treatment of the recipient will be provided by board certified physician specialists in physical medicine, neurology and orthopedics. ~~*(4-1-91)*~~(5-1-06)T

02. Billings. No more than five (5) hours of medical social services per recipient may

be billed by the specialty clinic each state fiscal year for which the medical social worker monitors and arranges recipient treatments and provides medical information to providers which have agreed to coordinate the care of their patient. (4-1-91)

03. Services Performed. Services performed or arranged by the clinic will be subject to the amount, scope and duration for each service as set forth elsewhere in this chapter. (12-31-91)

04. The Clinic. The clinic is established as a separate and distinct entity from the hospital, physician or other provider practices. (4-1-91)

05. Services Reimbursed. Services performed by a diagnostic and screening clinic will be reimbursed under a fee for service basis as established by Idaho Department of Health and Welfare Rules, IDAPA 16.03.10, Section 406, "Rules Governing Medicaid Provider Reimbursement in Idaho". (12-31-91)

46~~1~~2. -- 463. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

465. MENTAL HEALTH CLINIC PROVIDER AGENCY REQUIREMENTS.
Each agency that enters into a provider agreement with the Department for the provision of mental health clinic services must meet the following requirements: (4-6-05)

01. Mental Health Clinic. A mental health clinic, also referred to as "agency," must be a proprietorship, partnership, corporation, or other entity, in a distinct location, employing at least two (2) staff qualified to deliver clinic services under this rule and operating under the direction of a physician. The Department must approve the enrollment of the agency as a Medicaid provider. Each location of the agency must meet these requirements. All mental health clinic services must be provided at the clinic unless provided to an eligible homeless individual. (4-6-05)

02. Credentialing. The Department is phasing in the Credentialing Program in 2006. During the first three (3) years of development the following will take place. (5-1-06)T

a. Reimbursement. A mental health clinic must be designated as credentialed or provisionally credentialed in order to receive Medicaid reimbursement for services. Any agency that fails to maintain credentialed status will have its Medicaid provider agreement terminated. (5-1-06)T

b. Application. All existing providers and new provider applicants must submit an application for credentialing that will be reviewed in order to proceed with the credentialing process and obtain the required credential by the Department or its designee. All initial applications will be responded to within thirty (30) days indicating if the application is approved or additional information is required. The applicant must submit the additional information for the

application to be considered further. The application will be reviewed up to three (3) times. If the applicant has not provided the required information by the third submittal then the application will be denied and the application will not be considered again for twelve (12) months. (5-1-06)T

c. Temporary Credentialed Status. In order for existing providers to be able to continue to provide services during these first three (3) years the Department will grant a one-time temporary credential to all existing providers not to exceed three (3) years. (5-1-06)T

d. New Providers. Once the Credentialing Program is initiated any new provider applicants will be required to submit an application and successfully complete the credentialing process prior to billing for Medicaid services. (5-1-06)T

e. Elements of Credentialing. The credentialing process consists of the application and an on-site review. Whenever deficiencies are identified a plan of improvement approved by the Department or its designee must be submitted by the agency. (5-1-06)T

f. Expiration and Renewal of Credentialed Status. Credentials issued under these rules will be issued for a period up to three (3) years. Unless sooner suspended or revoked, the agency's credential will expire on the date designated by the Department or its designee. No later than ninety (90) days before expiration, an agency may apply for renewal of credentials. A site review may be conducted by the Department or its designee for renewal applications. (5-1-06)T

g. Provisional Credentialed Status. If a new or renewal applicant is found deficient in one (1) or more of the requirements for credentialing, but does not have deficiencies that jeopardize the health and safety of the participants or substantially affect the provider's ability to provide services, a provisional credential may be issued. Provisional credentials will be issued for a period not to exceed one hundred and eighty (180) days. During that time, the Department or its designee will determine whether the deficiencies have been corrected. If so, then the agency will be credentialed. If not, then the credential will be denied or revoked. (5-1-06)T

h. Denial, or Revocation of Credentialed Status. The Department or its designee may deny or revoke credentials when conditions exist that endanger the health, safety, or welfare of any participant or when the agency is not in substantial compliance with these rules. Additional causes for denial of credentials include the following: (5-1-06)T

i. The provider agency or provider agency applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining credentialed status; (5-1-06)T

ii. The provider agency or provider agency applicant has been convicted of, or is currently under investigation for fraud, gross negligence, abuse, assault, battery or exploitation; (5-1-06)T

iii. The provider agency or provider agency applicant has been convicted of a criminal offense within the past five (5) years, other than a minor traffic violation or similar minor offense; (5-1-06)T

iv. The provider agency or provider agency applicant has been denied or has had revoked any health facility license, or certificate; (5-1-06)T

v. A court has ordered that any provider agency owner or provider agency applicant must not operate a health facility, residential care or assisted living facility, or certified family home; (5-1-06)T

vi. Any owners, employees, or contractors of the provider agency or provider agency applicant are listed on the statewide Child Abuse Registry, Adult Protection Registry, Sexual Offender Registry, or Medicaid exclusion lists; (5-1-06)T

vii. The provider agency or provider agency applicant is directly under the control or influence, whether financial or other, of any person who is described in Subsections 465.02.h.i. through 465.02.h.vi. of these rules. (5-1-06)T

i. Procedure for Appeal of Denial or Revocation of Credentials. Immediately upon denial or revocation of credentials, the Department or the Department's designee will notify the applicant or provider in writing by certified mail or by personal service of its decision, the reason for its decision, and how to appeal the decision. The appeal is subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (5-1-06)T

0~~2~~3. Physician Requirement for Clinic Supervision. In order to fulfill the requirement that the clinic be under the direction of a physician, the clinic must have a contract with the physician. (4-6-05)

a. The contract must specifically require that the physician spend as much time in the facility as is necessary to assure that participants are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice. (4-6-05)

b. The supervising physician of the clinic may also serve as the supervising physician of a participant's care. (4-6-05)

0~~3~~4. Physician Requirement for Supervision of a Participant's Care. Each participant's care must be under the supervision of a physician directly affiliated with the clinic. Documentation of the affiliation must be kept in the clinic location. The clinic may have as many physician affiliations as is necessary in order to meet the needs of the volume of participants served in that location. The physician who supervises a participant's care does not have to deliver this service at the clinic nor does the physician have to be present at the clinic when the participant receives services at the clinic. In order to fulfill the requirement for physician supervision of a participant's care, the following conditions must also be met: (4-6-05)

a. The clinic and the physician must enter into a formal arrangement in which the physician must assume professional responsibility for the services provided; (4-6-05)

b. The physician must see the participant at least once to determine the medical necessity and appropriateness of clinic services; (4-6-05)

c. The physician must review and sign the individualized treatment plan as an indicator that the services are prescribed; and (4-6-05)

d. The physician must review and sign all updates to the individualized treatment plan that involve changes in the types or amounts of services. (4-6-05)

04~~5~~. **Assessment**. All treatment in mental health clinics must be based on an individualized assessment of the patient's needs, including a current mental status examination, and provided under the direction of a licensed physician. (4-6-05)

05~~6~~. **Criminal History Checks**. (4-6-05)

a. The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or clinical services have complied with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". (4-6-05)

b. Once an employee, subcontractor, or agent of the agency has completed a self-declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check. (4-6-05)

c. Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department or its designee when the agency learns of the conviction. (4-6-05)

06~~7~~. **Staff Qualifications**. The mental health clinic must assure that each agency staff person delivering clinical services to eligible MA participants has, at a minimum, one (1) or more of the following qualifications: (4-6-05)

a. Licensed Psychiatrist; (4-6-05)

b. Licensed Physician or licensed practitioner of the healing arts; (4-6-05)

c. Licensed Psychologist; (4-6-05)

d. Psychologist extender, registered with the Bureau of Occupational Licenses; (4-6-05)

e. Licensed Masters Social Worker, Licensed Clinical Social Worker, or Licensed Social Worker; (4-6-05)

f. Licensed Clinical Professional Counselor or Licensed Professional Counselor; (4-6-05)

g. Licensed Marriage and Family Therapist; (4-6-05)

h. Certified Psychiatric Nurse, R.N., as described in Subsection 456.02 of these rules;

(4-6-05)

i. Licensed Professional Nurse, R.N.; or (4-6-05)

j. Registered Occupational Therapist, O.T.R. (4-6-05)

0~~7~~8. Support Staff. For the purposes of this rule, support staff is any person who does not meet the qualifications of professionals as listed in Subsection 465.0~~6~~7 of these rules. The agency may elect to employ support staff to provide support services to participants. Such support services may include providing transportation, cooking and serving meals, cleaning and maintaining the physical plant, or providing general, non-professional supervision. Support staff must not deliver or assist in the delivery of services that are reimbursable by Medicaid.
~~*(4-6-05)*~~(5-1-06)T

0~~8~~9. Agency Employees and Subcontractors. Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency.
(4-6-05)

***~~09~~*10. Supervision**. The agency must ensure that staff providing clinical services are supervised according to the following guidelines: (4-6-05)

a. Standards and requirements for supervision set by the Bureau of Occupational Licenses are met; (4-6-05)

b. Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement; and (4-6-05)

c. Documentation of supervision must be maintained by the agency and be available for review by the Department or its designee. (4-6-05)

1~~0~~1. Continuing Education. The agency must ensure that all staff complete twenty (20) hours of continuing education annually in the field in which they are licensed. Documentation of the continuing education hours must be maintained by the agency and be available for review by the Department or its designee. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (4-6-05)

1~~1~~2. Informed Consent. The agency must ensure that participants who receive services through the agency have obtained informed consent from the participant or his legal guardian indicating agreement with all of the elements on the individualized treatment plan including choice of the provider agency, designated services, times, dates, frequencies, objectives, goals, and exit criteria. For minors, informed consent must be obtained from the minor's parent or legal guardian. (4-6-05)

13. Ethics. (2-1-05)T

a. The provider must adopt, adhere to and enforce among its staff who are providing

Medicaid reimbursable services a Code of Ethics similar to or patterned after one (1) of the following: (5-1-06)T

i. US Psychiatric Rehabilitation Association Code of Ethics found at http://www.uspra.org/i4a/pages/index.cfm?pageid=3601; (5-1-06)T

ii. National Association of Social Workers Code of Ethics found at http://www.naswdc.org/pubs/code/default.asp; (5-1-06)T

iii. American Psychological Association Code of Ethics found at http://www.apa.org/ethics/code.html; or (5-1-06)T

iv. American Counseling Association Code of Ethics found at http://www.counseling.org/Content/NavigationMenu/RESOURCES/ETHICS/ACA_Code_of_Ethics.htm. (5-1-06)T

v. Marriage and Family Therapists Code of Ethics found at www.aamft.org/resources/lrmplan/ethics/ethicscode2001.asp. (5-1-06)T

b. Evidence of the Agency's Code of Ethics, the discipline(s) upon which it is modeled, and each staff member's training on the code must be submitted to the Department or its designee upon request. (5-1-06)T

c. The Provider must develop a schedule for providing ethics training to its staff. (5-1-06)T

d. The ethics training schedule must provide that new employees receive the training during their first year of employment, and that all staff receive ethics training no less than four (4) hours every four (4) years thereafter. (5-1-06)T

466. INDIVIDUALIZED TREATMENT PLAN FOR MENTAL HEALTH CLINIC SERVICES.

A written individualized treatment plan is a medically-ordered plan of care. An individualized treatment plan must be developed and implemented for each participant receiving mental health clinic services. Treatment planning is reimbursable if conducted by a qualified professional identified in Subsection 465.0~~6~~7 of these rules. ~~(4-6-05)~~(5-1-06)T

01. Individualized Treatment Plan Development. The individualized treatment plan must be developed by the following: (4-6-05)

a. The clinic staff providing the services; and (4-6-05)

b. The adult participant, if capable, and the adult participant's legal guardian, or, in the case of a minor, the minor's parent or legal guardian. The participant or his parent or legal guardian may also choose others to participate in the development of the plan. (4-6-05)

02. Individualized Treatment Plan Requirements. An individualized treatment plan

must include the following, at a minimum: (4-6-05)

a. Statement of the overall goals and concrete, measurable treatment objectives to be achieved by the participant, including time frames for completion. The goals and objectives must be individualized and must be directly related to the clinic service needs that are identified in the assessment. (4-6-05)

b. Documentation of who participated in the development of the individualized treatment plan. (4-6-05)

i. The authorizing physician must sign and date the plan within (30) thirty calendar days from the initiation of treatment. (4-6-05)

ii. The adult participant, the adult participant's legal guardian or, in the case of a minor, the minor's parent or legal guardian, must sign the treatment plan indicating their participation in its development. If these signatures indicating participation in the development of the treatment plan are not obtained, then the agency must document in the participant's record the reason the signatures were not obtained, including the reason for the participant's refusal to sign. A copy of the treatment plan must be given to the adult participant and his legal guardian or to his parent or legal guardian if the participant is a minor. (4-6-05)

iii. Other individuals who participated in the development of the treatment plan must sign the plan. (4-6-05)

iv. The author of the treatment plan must sign the plan and include his title and credentials. (4-6-05)

c. The diagnosis of the participant must be documented by an examination and be made by a licensed physician or other licensed practitioner of the healing arts, licensed psychologist, licensed clinical professional counselor, or licensed clinical social worker within the scope of his practice under state law; and (4-6-05)

d. A problem list, and the type, frequency, and duration of treatment estimated to achieve all objectives based on the ability of the participant to effectively utilize services. (4-6-05)

03. Treatment Plan Review. The treatment plan review by the clinic and the participant must occur within one-hundred-twenty (120) days and every one-hundred-twenty (120) days thereafter. During the review, the clinic staff providing the services and the participant must review progress made on objectives and identify objectives that may be added, amended, or deleted from the individualized treatment plan. The attendees of the treatment plan review are determined by the adult participant or his legal guardian, or, in the case of a minor, his parent or legal guardian and clinic staff providing the services. (4-6-05)

04. Physician Review of Treatment Plan. Each individualized treatment plan must be reviewed and be completely rewritten and signed by a physician at least annually. Changes in the types or amount of services that are determined during treatment plan reviews must be

reviewed and signed by a physician. Projected dates for the participant's reevaluation and the rewrite of the individualized treatment plan must be recorded on the treatment plan. (4-6-05)

05. Authorization for Services. Authorization for services after the first year must be based on documentation of the following: (4-6-05)

a. Description of the ways the participant has specifically benefited from clinic services, and why he continues to need additional clinical services; and (4-6-05)

b. The participant's progress toward the achievement of therapeutic goals that would eliminate the need for the service to continue. (4-6-05)

467. CARE AND SERVICES IN MENTAL HEALTH CLINICS NOT REIMBURSED.

01. Inpatient Medical Facilities. The MA Program will not pay for mental health clinic services rendered to MA recipients residing in inpatient medical facilities including nursing homes, hospitals, or public institutions as defined in 42 CFR 435.1009; or (4-6-05)

02. Scope. Any service or supplies not included as part of the allowable scope of the MA Program; or (3-30-01)

03. Non-Qualified Persons. Services provided within the mental health clinic framework by persons other than those qualified to deliver services as specified in Subsection 465.0~~6~~7 of these rules. ~~*(4-6-05)*~~(5-1-06)T

468. EVALUATION AND DIAGNOSTIC SERVICES IN MENTAL HEALTH CLINICS.

01. Medical Psychosocial Histories. Medical psychosocial intake histories must be contained in all case files. (3-30-01)

02. Diagnosis and Individualized Treatment Plan. Information gathered will be used for establishing a participant data base used in part to formulate the diagnosis and individualized treatment plan. (4-6-05)

03. Qualified Therapist. The medical psychosocial intake and plan development is reimbursable if conducted by a primary therapist who, at a minimum, has one (1) or more of the following qualifications: (3-30-01)

a. Licensed Psychologist; or (7-1-99)

b. Psychologist extender, registered with the Bureau of Occupational Licenses; or (7-1-99)

c. Licensed Masters Social Worker, or Licensed Clinical Social Worker, or Licensed Social Worker; or (4-6-05)

d. Certified Psychiatric Nurse, R.N.; or (7-1-99)

e. Licensed Clinical Professional Counselor or Licensed Professional Counselor; or (4-6-05)

f. Licensed Physician or Licensed Psychiatrist; or (4-6-05)

g. Licensed Marriage and Family Therapist; or (3-15-02)

h. Licensed Professional Nurse (RN). (4-6-05)

04. Intake Assessment. If an individual who is not eligible for MA receives intake services from any staff not having the required degree(s) as provided in Subsection 468.03 of these rules, and later becomes eligible for MA, a new intake assessment and individualized treatment plan will be required which must be developed by a qualified staff person and authorized prior to any reimbursement. (4-6-05)

05. Non-Qualified Staff. Any delivery of evaluation, diagnostic service, or treatment designed by any person other than an agency staff person designated as qualified under Section 468 or Sections 466 or 469 of these rules, is not eligible for reimbursement under the MA Program. (4-6-05)

06. Psychological Testing. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses or functional impairments. (4-6-05)

a. Psychological testing may be provided as a reimbursable service when provided in direct response to a specific evaluation question. (4-6-05)

b. The psychological report must contain the reason for the performance of this service. (4-6-05)

c. Agency staff may deliver this service if they meet one (1) of the following qualifications: (4-6-05)

i. Licensed Psychologist; (4-6-05)

ii. Psychologist extenders as described in IDAPA 24.12.01, “Rules of the Idaho State Board of Psychologist Examiners”; or (4-6-05)

iii. A qualified therapist listed in Subsection 469.06 of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing. (4-6-05)

07. Psychiatric Diagnostic Interview Exam. A psychiatric diagnostic interview exam may be provided as a reimbursable service when delivered by one (1) of the following licensed professionals: (4-6-05)

a. Psychiatrist; (4-6-05)

b. Physician; (4-6-05)

c. Practitioner of the healing arts; (4-6-05)

d. Psychologist; (4-6-05)

e. Clinical social worker; ~~or~~ ~~(4-6-05)~~(5-1-06)T

f. Clinical professional counselor~~.~~; or ~~(4-6-05)~~(5-1-06)T

g. Licensed Marriage and Family Therapist. (5-1-06)T

08. Evaluations Performed by Occupational Therapists. Evaluations performed by qualified registered occupational therapists, O.T.R., performed in conjunction with the development of an individualized treatment plan are reimbursable. (4-6-05)

09. Documentation. All intake histories, psychiatric evaluations, psychological testing, or specialty evaluations must be in written form, dated, and fully signed to certify when completed and by whom, and retained in the participant's file for documentation purposes. (4-6-05)

10. Data. All data gathered must be directed towards formulation of a written diagnosis, problem list, and individualized treatment plan which specifies the type, frequency, and anticipated duration of treatment. (4-6-05)

11. Limitations. A total of twelve (12) hours is the maximum time allowed for a combination of any evaluative or diagnostic services and individualized treatment plan development provided to an eligible participant in a calendar year. (4-6-05)

469. TREATMENT SERVICES IN MENTAL HEALTH CLINICS.

01. Psychotherapy. Individual and group psychotherapy must be provided in accordance with the goals specified in the individualized treatment plan. (4-6-05)

02. Family Psychotherapy. Family psychotherapy services must include at least two (2) family members and must be delivered in accordance with the goals of treatment as specified in the individualized treatment plan. (4-6-05)

03. Emergency Services. Individual emergency psychotherapy services can be provided by qualified clinic staff at any time. (3-30-01)

a. Emergency services provided to an eligible participant prior to intake and evaluation is a reimbursable service but must be fully documented in the participant's record; and (4-6-05)

b. Each emergency service will be counted as a unit of service and part of the allowable limit per participant unless the contact results in hospitalization. Provider agencies may submit claims for the provision of psychotherapy in emergency situations in accordance with Subsections 469.06 and 469.07 of these rules even when contact does not result in the hospitalization of the participant. (4-6-05)

04. Collateral/Contact Consultation. Collateral contact will be covered by Medicaid if it is conducted face to face by agency staff qualified to deliver clinical services, and if it is included on the individualized treatment plan and is necessary to gather and exchange information with individuals having a primary relationship to the participant. (4-6-05)

05. Nursing Facility. Psychotherapy services may be provided to participants residing in a nursing facility if the following criteria are met: (4-6-05)

a. The participant has been identified through the PASARR Level II screening process as requiring psychotherapy as a specialized service; and (4-6-05)

b. The service is provided outside the nursing facility at a clinic location; and (3-30-01)

c. Services provided are: (11-29-91)

i. Supported by the independent evaluations completed and approved by the Department or its designee; and (4-6-05)

ii. Incorporated into the participant's medical care plan; and (4-6-05)

iii. Directed toward the achievement of specific measurable objectives which include target dates for completion. (11-29-91)

06. Staff Qualifications for Psychotherapy Services. Licensed, qualified professionals providing psychotherapy services as set forth in Subsections 469.01 through 469.03 of these rules must have, at a minimum, one (1) or more of the following degrees: (4-6-05)

a. Licensed Psychiatrist; or (4-6-05)

b. Licensed Physician; or (4-6-05)

c. Licensed Psychologist; or (7-1-99)

d. Licensed Clinical Social Worker; or (4-6-05)

e. Licensed Clinical Professional Counselor; or (4-6-05)

f. Licensed Marriage and Family Therapist; or (4-6-05)

g. Certified Psychiatric Nurse (RN), as described in Subsection 456.02 of these rules; or (4-6-05)

h. Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified under Subsections 469.06.a. through 469.06.g. of this rule; or (4-6-05)

i. Licensed Masters Social Worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; or (4-6-05)

j. A Psychologist Extender, registered with the Bureau of Occupational Licenses. (4-6-05)

07. Psychotherapy Limitations. Psychotherapy services as set forth in Subsections 469.01 through 469.03 of these rules are limited to forty-five (45) hours per calendar year. (3-15-02)

08. Pharmacological Management. Pharmacological management consultations must be provided by a physician or other practitioner of the healing arts within the scope of practice defined in their license in direct contact with the participant. (4-6-05)

a. Consultation must be for the purpose of prescribing, monitoring, and/or administering medication as part of the individualized treatment plan; and (4-6-05)

b. Pharmacological management, if provided, must be part of the individualized treatment plan and frequency and duration of the treatment must be specified. (4-6-05)

09. Nursing Services. Nursing services, when physician ordered and supervised, can be part of the participant's individualized treatment plan. (4-6-05)

a. Licensed and qualified nursing personnel can supervise, monitor, and administer medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code; and (4-6-05)

b. The frequency and duration of the treatment must be specified on the participant's individualized treatment plan. (4-6-05)

10. Partial Care. Partial Care is treatment for those whose functioning is sufficiently disrupted so as to interfere with their productive involvement in daily living. Partial Care services are a structured program of therapeutic interventions that assist program participants in the stabilization of their behavior and conduct through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition. The goal of Partial Care services is to decrease the severity and acuity of presenting symptoms so that the program participant may be maintained in the least restrictive setting and to

increase the program participants' interpersonal skills in order to obtain the optimal level of interpersonal adjustment. (4-6-05)

a. Qualifications of Partial Care Services. In order to be considered a Partial Care service, the service must: (4-6-05)

i. Be provided in a structured environment within the MHC setting; (4-6-05)

ii. Be a needed service as indicated on the individualized treatment plan with documented, concrete, and measurable goals and outcomes; and (4-6-05)

iii. Provide interventions for relieving symptoms and acquiring specific skills. These interventions must include the specific medical services, therapies, and activities that are used to meet the treatment objectives. (4-6-05)

b. Limit on Treatment Hours. Treatment will be limited to thirty-six (36) hours per week per eligible participant. (4-6-05)

c. Criteria for Partial Care Service Program Participants. In order for a MHC program participant to be eligible for Partial Care Services the following criteria must be met and documented: (4-6-05)

i. Assessments completed within the previous twelve (12) months have documented that the participant has any combination of emotional, behavioral, neurobiological or substance abuse problems that significantly impair social and occupational functioning. The intake assessment must document that the participant is presently at risk for an out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration which would interfere with the participant's ability to maintain current level of functioning. (4-6-05)

ii. Other services have failed or are not appropriate for the clinical needs of the participant. (4-6-05)

iii. For each participant, the services can reasonably be expected to improve the participant's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced. (4-6-05)

d. Partial care service is not appropriate for certain people. Persons identified in the list below are disqualified from participating in Partial Care services: (4-6-05)

i. Persons at immediate risk of self-harm or harm to others; (4-6-05)

ii. Persons needing more restrictive care or inpatient care; and (4-6-05)

iii. Persons who have not fulfilled the requirements of Subsection 469.10.c. of this rule. (4-6-05)

e. Partial Care Services Must Be on the Individualized Treatment Plan. Partial care services must be part of the participant's individualized treatment plan which must identify the specific objective to be addressed through the service and specify the amount, frequency, and expected duration of treatment. (4-6-05)

f. Staff Qualifications for Partial Care Services. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the qualifications listed in Subsection 465.0~~6~~7 of these rules. ~~*(4-6-05)*~~(5-1-06)T

g. Excluded Services. Services that focus on vocation, recreation or education are not reimbursable under Medicaid Partial Care. Services that are provided outside the clinic facility are not reimbursable. (4-6-05)

470. RECORD KEEPING REQUIREMENTS FOR MENTAL HEALTH CLINICS.

01. Maintenance. Each mental health clinic will be required to maintain records on all services provided to MA participants. (4-6-05)

02. Record Contents. The records must contain the current individualized treatment plan ordered by a physician and must meet the requirements as set forth in Section 466. (4-6-05)

03. Requirements. The records must: (3-30-01)

a. Specify the exact type of treatment provided; and (11-10-81)

b. Who the treatment was provided by; and (11-10-81)

c. Specify the duration of the treatment and the time of day delivered; and (4-6-05)

d. Contain detailed records which outline exactly what occurred during the therapy session or participant contact documented by the person who delivered the service; and (4-6-05)

e. Contain the legible, dated signature, with degree credentials listed, of the staff member performing the service. (11-10-81)

04. Non-Reimbursable. Any service not adequately documented in the participant's record by the signature of the therapist providing the therapy or participant contact, the length of the therapy session, and the date of the contact, will not be reimbursed by the Department. (4-6-05)

05. Non-Eligible Staff. Any treatment or contact provided as a result of an individualized treatment plan that is performed by any staff other than those qualified to deliver services under Subsection 465.0~~6~~7 of these rules is not be eligible for reimbursement by the Department. ~~*(4-6-05)*~~(5-1-06)T

06. Recoupment. If a record is determined not to meet minimum requirements as set forth herein any payments made on behalf of the participant are subject to recoupment. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

472. BUILDING STANDARDS FOR MENTAL HEALTH CLINICS.

01. Accessibility. Mental health clinic service providers must be responsive to the needs of the service area and persons receiving services and accessible to persons with disabilities as defined in Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act, and the uniform federal accessibility standard. (4-6-05)

02. Environment. Clinics must be designed and equipped to meet the needs of each participant including, but not limited to, factors such as sufficient space, equipment, lighting and noise control. (4-6-05)

03. Capacity. Clinics must provide qualified staff as listed in Subsection 465.0~~6~~7 of these rules to meet a staff to participant ratio that ensures safe, effective and clinically appropriate interventions. ~~*(4-6-05)*~~(5-1-06)T

04. Fire and Safety Standards. (4-6-05)

a. Clinic facilities must meet all local and state codes concerning fire and life safety. The owner/operator must have the facility inspected at least annually by the local fire authority. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A copy of the inspection must be made available upon request and must include documentation of any necessary corrective action taken on violations cited; and (4-6-05)

b. The clinic facility must be structurally sound and must be maintained and equipped to assure the safety of participants, employees and the public; and (4-6-05)

c. In clinic facilities where natural or man-made hazards are present, suitable fences, guards or railings must be provided to protect participants; and (4-6-05)

d. Clinic facilities must be kept free from the accumulation of weeds, trash and rubbish; and (4-6-05)

e. Portable heating devices are prohibited except units that have heating elements that are limited to not more than two hundred twelve (212F) degrees Fahrenheit. The use of unvented, fuel-fired heating devices of any kind are prohibited. All portable space heaters must be U.L. approved as well as approved by the local fire or building authority; and (4-6-05)

f. Flammable or combustible materials must not be stored in the clinic facility; and (4-6-05)

g. All hazardous or toxic substances must be properly labeled and stored under lock and key; and (4-6-05)

h. Water temperatures in areas accessed by participants must not exceed one hundred twenty (120) degrees Fahrenheit; and (4-6-05)

i. Portable fire extinguishers must be installed throughout the clinic facility. Numbers, types and location must be directed by the applicable fire authority noted in Subsection 472.04 of these rules; and (4-6-05)

j. Electrical installations and equipment must comply with all applicable local or state electrical requirements. In addition, equipment designed to be grounded must be maintained in a grounded condition and extension cords and multiple electrical outlet adapters must not be utilized unless U.L. approved and the numbers, location, and use of them are approved, in writing, by the local fire or building authority. (4-6-05)

k. There must be a telephone available on the premises for use in the event of an emergency. Emergency telephone numbers must be posted near the telephone or where they can be easily accessed; and (4-6-05)

l. Furnishings, decorations or other objects must not obstruct exits or access to exits. (4-6-05)

05. Emergency Plans and Training Requirements. (4-6-05)

a. Evacuation plans must be posted throughout the facility. Plans must indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of building. (4-6-05)

b. There must be written policies and procedures covering the protection of all persons in the event of fire or other emergencies; and (4-6-05)

c. All employees must participate in fire and safety training upon employment and at least annually thereafter; and (4-6-05)

d. All employees and partial care participants must engage in quarterly fire drills. At least two (2) of these fire drills must include evacuation of the building; and (4-6-05)

e. A brief summary of the fire drill and the response of the response of the employees and partial care participants must be written and maintained on file. The summary must indicate the date and time the drill occurred, problems encountered and corrective action taken. (4-6-05)

06. Food Preparation and Storage. (4-6-05)

a. If foods are prepared in the clinic facility, they must be stored in such a manner as to prevent contamination and be prepared by sanitary methods. (4-6-05)

b. Except during actual preparation time, cold perishable foods must be stored and served under forty-five (45F) degrees Fahrenheit and hot perishable foods must be stored and

served over one hundred forty (140F) degrees Fahrenheit. (4-6-05)

c. Refrigerators and freezers used to store participant lunches and other perishable foods used by participants, must be equipped with a reliable, easily-readable thermometer. Refrigerators must be maintained at forty-five (45F) degrees Fahrenheit or below. Freezers must be maintained at zero (0F) to ten (10F) degrees Fahrenheit or below. (4-6-05)

d. When meals are prepared or provided for by the clinic, meals must be nutritional. (4-6-05)

07. Housekeeping and Maintenance Services. (4-6-05)

a. The interior and exterior of the clinic facility must be maintained in a clean, safe and orderly manner and must be kept in good repair; and (4-6-05)

b. Deodorizers cannot be used to cover odors caused by poor housekeeping or unsanitary conditions; and (4-6-05)

c. All housekeeping equipment must be in good repair and maintained in a clean, safe and sanitary manner; and (4-6-05)

d. The clinic facility must be maintained free from infestations of insects, rodents and other pests; and (4-6-05)

e. The clinic facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means. (4-6-05)

f. Garbage will be disposed of in a sanitary manner. It must not be allowed to accumulate and must be placed in leak-proof bags. (4-6-05)

08. Firearms. No firearms are permitted in the clinic facility. (4-6-05)

09. Plumbing. Restroom facilities must be maintained in good working order and available and accessible to participants while at the clinic in accordance with the Americans with Disabilities Act. This includes the presence of running water for operation of the toilet and washing hands. (4-6-05)

10. Lighting. Lighting levels must be maintained throughout the clinic facility which are appropriate to the service being provided. (4-6-05)

11. Drinking Water. Where the source is other than a public water system or commercially bottled, water quality must be tested and approved annually by the district health department. (4-6-05)

HEALTH AND WELFARE

IDAPA 58 - DEPARTMENT OF ENVIRONMENTAL QUALITY

58.01.08 - IDAHO RULES FOR PUBLIC DRINKING WATER SYSTEMS

DOCKET NO. 58-0108-0601

NOTICE OF RULEMAKING - TEMPORARY RULE

EFFECTIVE DATE: The temporary rule was effective November 17, 2005.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that the Board of Environmental Quality has adopted a temporary rule and the Department of Environmental Quality (DEQ) is commencing proposed rulemaking. This action is authorized by Chapter 1, Title 39, Idaho Code, and Chapter 21, Title 37, Idaho Code.

PUBLIC HEARING SCHEDULE: No hearings have been scheduled. Pursuant to Section 67-5222(2), Idaho Code, a public hearing will be held if requested in writing by twenty-five (25) persons, a political subdivision, or an agency. Written requests for a hearing must be received by the undersigned on or before January 18, 2006. If no such written request is received, a public hearing will not be held.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: DEQ has initiated this rulemaking to allow public drinking water systems the flexibility to use point of use (POU) treatment technology for treating some chemical contaminants such as arsenic. The rule will exempt small public drinking water systems from the requirement in Section 39-118, Idaho Code, to submit engineering plans and specifications if they serve less than 200 service connections and submit technical and managerial documentation to the Department. The rule also allows public drinking water systems serving over 200 service connections the option to apply to the state for a waiver of the engineering plan and specification requirements.

After consideration of public comments, DEQ intends to present the final proposal to the Board of Environmental Quality for adoption of a pending rule in February 2006. The pending rule will become final upon the conclusion of the 2007 session of the Idaho Legislature if approved by the Legislature.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is necessary in order to confer a benefit. The benefit is the increased flexibility for public water systems to use point of use treatment devices for treating some chemical contaminants such as arsenic. Additionally, the rule provides a cost savings by waiving engineering plans and specifications required by Section 39-118, Idaho Code, for systems serving less than 200 service connections. It was necessary to make this rule immediately effective to ensure that the point of use treatment alternative is available prior to the revised federal arsenic standard for drinking water becoming effective on January 23, 2006.

IDAHO CODE SECTION 39-107D STATEMENT: Previous federal regulation prohibited use of POU treatment devices for compliance with National Primary Drinking Water Regulations. In

1996, the United States Congress removed this prohibition through language in the Safe Drinking Water Act, 42 U.S.C. Section 300g-1(b)(4)(E)(ii).

The revised arsenic standard of 10 parts per billion for drinking water will become effective on January 23, 2006. *See* National Primary Drinking Water Regulations; Arsenic and Clarifications to Compliance and New Source Contaminants Monitoring, 66 Fed. Reg. 6975-7066, incorporated by reference into Idaho Rules for Public Drinking Water Systems, IDAPA 58.01.08. In order to assist communities with complying with the revised arsenic standard, DEQ proposes this rule allowing for use of POU treatment devices as allowed per federal law.

Idaho Code Section 39-107D provides that DEQ must meet certain requirements when it formulates and recommends rules which are broader in scope or more stringent than federal law or regulations, or which propose to regulate an activity not regulated by the federal government. This rule incorporates language from the Safe Drinking Water Act (42 U.S.C.Section 300g-1(b)(4)(E)(ii)). The Safe Drinking Water Act states that POU treatment devices "shall be owned, controlled and maintained by the public water system or by a person under contract with the public water system to ensure proper operation and maintenance and compliance with the maximum contaminant level or treatment technique". Id. To that end, this rule includes language DEQ deems necessary in order to ensure that POU treatment devices are operated and maintained pursuant to federal law.

Although the federal Safe Drinking Water Act does not specifically prohibit use of POU treatment devices for compliance with the nitrate maximum contaminant level (MCL), this rule is more restrictive in that it does not allow POU for the nitrate MCL in community water systems because of the risk of acute illness for infants. POU treatment systems may still be used for compliance with nitrate standards for non-community water systems under certain conditions where the risk of acute illness is low. The nitrate MCL was promulgated in 1975 by the Public Health Service and re-promulgated in 1991 by EPA (56 CFR 3526).

POU treatment devices may be covered under the definition of "material modification" outlined in Section 39-118, Idaho Code, and be subject to plan and specification review. However, because the POU treatment devices are ANSI/NSF certified pre-engineered units and are not being constructed individually onsite, DEQ has determined that these devices will not produce a significant impact on the environment or on public health, and therefore waives plan and specification review for certain small public water systems as specified in the rule. The main public health and environmental concern associated with POU treatment devices pertains to the proper operation and maintenance of the units.

IDAHO CODE SECTION 67-5221(1)(c) FISCAL IMPACT STATEMENT: No negative impact occurs from this rulemaking; provision is not applicable.

NEGOTIATED RULEMAKING: This temporary rulemaking schedule did not allow for negotiated rulemaking.

GENERAL INFORMATION: For more information about DEQ's programs and activities, visit DEQ's web site at www.deq.idaho.gov.

ASSISTANCE ON TECHNICAL QUESTIONS AND SUBMISSION OF WRITTEN COMMENTS: For assistance on questions concerning the temporary and proposed rule, contact Jerri Henry at jerri.henry@deq.idaho.gov, (208)373-0471.

Anyone may submit written comments regarding this proposed rule by mail, fax or e-mail at the address below. DEQ will consider all written comments received by the undersigned on or before February 1, 2006.

DATED this 16th day of November, 2005.

Paula J. Wilson
Hearing Coordinator
Department of Environmental Quality
1410 N. Hilton, Boise, Idaho 83706-1255
(208)373-0418/Fax No. (208)373-0481
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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

003. DEFINITIONS.
The definitions set forth in 40 CFR 141.2, revised as of July 1, 2002, are herein incorporated by reference except for the definition of the terms "action level," "disinfection," "noncommunity water system," and "person". (5-3-03)

There are no changes to Subsections 003.01 through 003.41

42. **Maximum Contaminant Level (MCL)**. The maximum permissible level of a contaminant in water which is delivered to any user of a public water system. (11-17-05)T

4~~2~~3. Maximum Daily Consumption Rate. The average rate of consumption for the twenty-four (24) hour period in which total consumption is the largest on record. (12-10-92)

4~~3~~4. Maximum Hourly Demand. The greatest volume of water used in any hour during a one (1) year period. (12-10-92)

4~~4~~5. Maximum Residual Disinfectant Level (MRDL). A level of a disinfectant added for water treatment that may not be exceeded at the consumer's tap without an unacceptable possibility of adverse health effects. For chlorine and chloramines, a public water system is in compliance with the MRDL, when the running annual average of monthly averages of samples taken in the distribution system, computed quarterly, is less than or equal to the MRDL. For chlorine dioxide, a public water system is in compliance with the MRDL when daily samples are taken at the entrance to the distribution system and no two (2) consecutive daily samples exceed

the MRDL. MRDLs are enforceable in the same manner as maximum contaminant levels under Section 1412 of the Safe Drinking Water Act. There is convincing evidence that addition of a disinfectant is necessary for control of waterborne microbial contaminants. Notwithstanding the MRDLs listed in 40 CFR 141.65, operators may increase residual disinfectant levels of chlorine or chloramines (but not chlorine dioxide) in the distribution system to a level and for a time necessary to protect public health to address specific microbiological contamination problems caused circumstances such as distribution line breaks, storm runoff events, source water contamination, or cross-connections. (4-5-00)

4~~5~~6. Maximum Residual Disinfectant Level Goal (MRDLG). The maximum level of a disinfectant added for water treatment at which no known or anticipated adverse effect on the health of persons would occur, and which allows an adequate margin of safety. MRDLGs are nonenforceable health goals and do not reflect the benefit of the addition of the chemical for control of waterborne microbial contaminants. (4-5-00)

4~~6~~7. Method Detection Limit (MDL). The lowest concentration which can be determined to be greater than zero with ninety-nine percent (99%) confidence, for a particular analytical method. (12-10-92)

4~~7~~8. New System. Any water system that meets, for the first time, the definition of a public water system provided in Section 1401 of the federal Safe Drinking Water Act (42 U.S.C. Section 300f). This includes systems that are entirely new construction and previously unregulated systems that are expanding. (4-5-00)

4~~8~~9. Noncommunity Water System. A public water system that is not a community water system. A non-community water system is either a transient noncommunity water system or a non-transient noncommunity water system. (4-5-00)

~~49~~50. Nontransient Noncommunity Water System. A public water system that is not a community water system and that regularly serves at least twenty-five (25) of the same persons over six (6) months per year. (12-10-92)

5~~0~~1. Nuclear Facility. Factories, processing plants or other installations in which fissionable material is processed, nuclear reactors are operated, or spent (used) fuel material is processed, or stored. (12-10-92)

5~~1~~2. Operating Shift. That period of time during which water system operator decisions that affect public health are necessary for proper operation of the system. (4-5-00)

5~~2~~3. Owner/Purveyor of Water/Supplier of Water. The person, company, corporation, association, or other organizational entity which holds legal title to the public water system, who provides, or intends to provide, drinking water to the customers and/or is ultimately responsible for the public water system operation. (4-6-05)

5~~3~~4. Peak Hourly Flow. The highest hourly flow during any day. (12-10-92)

5~~4~~5. Person. A human being, municipality, or other governmental or political

subdivision or other public agency, or public or private corporation, any partnership, firm, association, or other organization, any receiver, trustee, assignee, agent or other legal representative of the foregoing or other legal entity. (12-10-92)

5~~5~~6. **Pesticides**. Substances which meet the criteria for regulation pursuant to the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), as amended, and any regulations adopted pursuant to FIFRA. For example, pesticides include, but are not limited to insecticides, fungicides, rodenticides, herbicides, and algaecides. (12-10-92)

57. **Point of Use (POU) Treatment Device**. A treatment device applied to a single tap used for the purpose of reducing contaminants in drinking water at that one tap. (11-17-05)T

58. **Point of Use (POU) Treatment System**. A collection of POU treatment devices. (11-17-05)T

5~~6~~9. **Public Notice**. The notification of public water system consumers of information pertaining to that water system including information regarding water quality or compliance status of the water system. (12-10-92)

~~57~~60. **Public Drinking Water System**. A system for the provision to the public of water for human consumption through pipes or, after August 5, 1998, other constructed conveyances, if such system has at least fifteen (15) service connections, regardless of the number of water sources or configuration of the distribution system, or regularly serves an average of at least twenty-five (25) individuals daily at least sixty (60) days out of the year. Such term includes: any collection, treatment, storage, and distribution facilities under the control of the operator of such system and used primarily in connection with such system; and any collection or pretreatment storage facilities not under such control which are used primarily in connection with such system. Such term does not include any "special irrigation district". A public water system is either a "community water system" or a "noncommunity water system". (4-6-05)

~~58~~61. **Public Water System/Water System/System**. Means "public drinking water system". (4-5-00)

~~59~~62. **Repeat Compliance Period**. Any subsequent compliance period after the initial compliance period. (12-10-92)

6~~0~~3. **Responsible Charge (RC)**. Responsible Charge means, active, daily on-site and/or on-call responsibility for the performance of operations or active, on-going, on-site and on-call direction of employees and assistants. (4-5-00)

6~~1~~4. **Responsible Charge Operator**. An operator of a public drinking water system, designated by the system owner, who holds a valid license at a class equal to or greater than the drinking water system classification, who is in responsible charge of the public drinking water system. (4-6-05)

6~~2~~5. **Sampling Point**. The location in a public water system from which a sample is drawn. (12-10-92)

6~~3~~6. Sanitary Defects. Any faulty structural condition which may allow the water supply to become contaminated. (12-10-92)

6~~4~~7. Sanitary Survey. An onsite review of the water source, facilities, equipment, operation and maintenance of a public water system for the purpose of evaluating the adequacy of such source, facilities, equipment, operation and maintenance for producing and distributing safe drinking water. The sanitary survey will include, but is not limited to the following elements: (4-5-00)

a. Source; (4-5-00)

b. Treatment; (4-5-00)

c. Distribution system; (4-5-00)

d. Finished water storage; (4-5-00)

e. Pumps, pump facilities, and controls; (4-5-00)

f. Monitoring and reporting and data verification; (4-5-00)

g. System management and operation; and (4-5-00)

h. Operator compliance with state requirements. (4-5-00)

6~~5~~8. SDWIS-State. An acronym that stands for "Safe Drinking Water Information System-State Version". It is a software package developed under contract to the U.S. Environmental Protection Agency and used by a majority of U.S. states to collect, maintain, and report data about regulated public water systems. See also the definition of DWIMS. (5-3-03)

6~~6~~9. Significant Deficiency. As identified during a sanitary survey, any defect in a system's design, operation, maintenance, or administration, as well as any failure or malfunction of any system component, that the Department or its agent determines to cause, or have potential to cause, risk to health or safety, or that could affect the reliable delivery of safe drinking water. See also the definition of Health Hazards. (5-3-03)

***~~6~~*70. Special Irrigation District**. An irrigation district in existence prior to May 18, 1994 that provides primarily agricultural service through a piped water system with only incidental residential or similar use where the system or the residential or similar users of the system comply with the exclusion provisions in Section 1401(4)(B)(i)(II) or (III) of the Safe Drinking Water Act. (4-6-05)

***~~68~~*71. Spring**. A source of water which flows from a laterally percolating water table's intersection with the surface or from a geological fault that allows the flow of water from an artesian aquifer. (12-10-92)

~~69~~72. Substitute Responsible Charge Operator. An operator of a public drinking water system who holds a valid license at a class equal to or greater than the drinking water system classification, designated by the system owner to replace and to perform the duties of the responsible charge operator when the responsible charge operator is not available or accessible. (4-6-05)

7~~0~~3. Surface Water System. A public water system which is supplied by one (1) or more surface water sources or groundwater sources under the direct influence of surface water. Also called subpart H systems in applicable sections of 40 CFR Part 141. (4-5-00)

7~~1~~4. Specific Ultraviolet Absorption (SUVA). SUVA means Specific Ultraviolet Absorption at two hundred fifty-four (254) nanometers (nm), an indicator of the humic content of water. It is a calculated parameter obtained by dividing a sample's ultraviolet absorption at a wave length of two hundred fifty-four (254) nm (UV254) (in m^{-1}) by its concentration of dissolved organic carbon (DOC) (in mg/l). (4-5-00)

7~~2~~5. Total Organic Carbon (TOC). Total organic carbon in mg/l measured using heat, oxygen, ultraviolet irradiation, chemical oxidants, or combinations of these oxidants that convert organic carbon to carbon dioxide, rounded to two (2) significant figures. (4-5-00)

7~~3~~6. Transient Noncommunity Water System. A noncommunity water system which does not regularly serve at least twenty-five (25) of the same persons over six (6) months per year. (10-1-93)

7~~4~~7. Treatment Facility. Any place(s) where a public drinking water system or nontransient noncommunity water system alters the physical or chemical characteristics of the drinking water. Chlorination may be considered as a function of a distribution system. (4-5-00)

7~~5~~8. Turbidity. A measure of the interference of light passage through water, or visual depth restriction due to the presence of suspended matter such as clay, silt, nonliving organic particulates, plankton and other microscopic organisms. Operationally, turbidity measurements are expressions of certain light scattering and absorbing properties of a water sample. Turbidity is measured by the Nephelometric method. (12-10-92)

7~~6~~9. Uncovered Finished Water Storage Facility. An uncovered tank, reservoir, or other facility that is used to store water that will undergo no further treatment except residual disinfection. (5-3-03)

~~77~~80. Unregulated Contaminant. Any substance that may affect the quality of water but for which a maximum contaminant level or treatment technique has not been established. (12-10-92)

~~7~~81. Variance. A temporary deferment of compliance with a maximum contaminant level or treatment technique requirement which may be granted only when the system demonstrates to the satisfaction of the Department that the raw water characteristics prevent compliance with the MCL or requirement after installation of the best available technology or treatment technique and the determent does not cause an unreasonable risk to public health.

(12-10-92)

~~79~~**82. Very Small Public Drinking Water System**. A Community or Nontransient Noncommunity Public Water System that serves five hundred (500) persons or less and has no treatment other than disinfection or has only treatment which does not require any chemical treatment, process adjustment, backwashing or media regeneration by an operator (e.g. calcium carbonate filters, granular activated carbon filters, cartridge filters, ion exchangers). (4-5-00)

8~~0~~**3. Volatile Organic Chemicals (VOCs)**. VOCs are lightweight organic compounds that vaporize or evaporate easily. (10-1-93)

8~~1~~**4. Vulnerability Assessment**. A determination of the risk of future contamination of a public drinking water supply. (12-10-92)

8~~2~~**5. Waiver**. (12-10-92)

a. For the purposes of these rules, except Sections 550 through 552, "waiver" means the Department approval of a temporary reduction in sampling requirements for a particular contaminant. (10-1-93)

b. For purposes of Sections 550 through 552, "waiver" means a dismissal of any requirement of compliance. (12-10-92)

c. For the purposes of Section 010, "waiver" means the deferral of a fee assessment for a public drinking water system. (10-1-93)

8~~3~~**6. Water for Human Consumption**. Water that is used by humans for drinking, bathing for purposes of personal hygiene (including hand-washing), showering, cooking, dishwashing, and maintaining oral hygiene. In common usage, the terms "culinary water," "drinking water," and "potable water" are frequently used as synonyms. (5-3-03)

8~~4~~**7. Water Main**. A pipe within a public water system which is under the control of the system operator and conveys water to two (2) or more service connections. The collection of water mains within a given water supply is called the distribution system. (5-3-03)

8~~5~~**8. Well House**. A structure containing important water system components, such as a well, hydropneumatic tank, booster pump, pump controls, flow meter, distribution line, or a treatment unit. Well houses are often called pump houses in common usage, even though in modern construction these structures may not contain either a well or a pump. These terms are used interchangeably in national standards and trade publications. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

450. USE OF NON-CENTRALIZED TREATMENT DEVICES.

01. Point of Entry Devices. 40 CFR 141.100, revised as of July 1, 1999, is herein incorporated by reference. (4-5-00)

02. Point of Use (POU) Treatment Devices. (11-17-05)T

a. A public water system may use point of use (POU) treatment in order to achieve compliance with certain maximum contaminant levels (MCL) or treatment techniques, in accordance with Subsection 450.02.b., when the following conditions are met: (11-17-05)T

i. A program for long-term operation, maintenance, and monitoring of the POU treatment system is approved by the Department, pursuant to Section 450.02.d. (11-17-05)T

ii. The public water system or a vendor of POU treatment devices under contract with the public water system shall own, control, and maintain the POU treatment system to ensure proper operation and maintenance and compliance with the MCL or treatment technique. (11-17-05)T

iii. Each POU treatment device is equipped with a mechanical warning mechanism to ensure that customers are automatically notified of operational problems. (11-17-05)T

iv. The POU treatment device must be certified by an accredited American National Standards Institute (ANSI) certification body to meet applicable ANSI/National Sanitation Foundation (NSF) Standards. (11-17-05)T

b. POU treatment devices shall not be used to achieve compliance with a MCL or treatment technique requirement for a microbial contaminant or an indicator of a microbial contaminant. Community water systems may not use POU treatment devices to achieve compliance with a nitrate MCL. (11-17-05)T

c. The Department will waive the plan and specification requirements as described in Subsection 551.04 relating to material modifications for the following systems only to that extent that the material modification proposed is limited to the installation and/or use of a POU treatment device(s): (11-17-05)T

i. Community water systems serving two hundred (200) or fewer service connections. (11-17-05)T

ii. Non-transient non-community water systems. (11-17-05)T

iii. Transient non-community water systems. (11-17-05)T

iv. Community water systems serving more than two hundred (200) service connections if approved by the Department through the waiver process outlined in Subsection 005.01.a. (11-17-05)T

d. A public water system must obtain written approval by the Department before installation of a POU treatment device for the purpose of achieving compliance with a MCL or

treatment technique. The public water system shall submit the following documentation for approval to the Department: (11-17-05)T

i. Information identifying the public water system name and number, total number of service connections, contaminant(s) to be treated, type of POU treatment device to be installed, manufacturer and model number of the POU treatment device, type and function of the mechanical warning mechanism (performance indicator) on the POU treatment device, certification verification for ANSI/NSF, installer qualifications, and a proposed date for installation of the POU treatment device(s). (11-17-05)T

ii. The manufacturer's specifications for the POU treatment device including demonstration that the POU treatment device is suited for the water chemistry of the public water system and contaminant(s) of concern and is of sufficient design and capacity for the particular application. (11-17-05)T

iii. Information relating to how other drinking water dispensing units, such as instant hot water dispensers and refrigerator water and ice dispensers, whose primary function is to provide drinking water, will be provided with treated water. If water is transported from a POU treatment device to another drinking water dispensing unit, the conducting tube shall be of non-reactive material. (11-17-05)T

iv. For non-transient non-community water systems and transient non-community water systems, demonstration that the drinking water dispensing units are located in areas adequate to protect public health. (11-17-05)T

v. Demonstration that all POU treatment devices are owned, controlled, and maintained by the public water system or by a vendor of POU treatment devices under contract with the public water system. (11-17-05)T

vi. A sampling plan identifying the location of all service connections and demonstrating how the system will ensure that all POU treatment devices are sampled for compliance with the contaminant(s) being treated during every compliance period or at a frequency designated by the state. (11-17-05)T

vii. Documentation that a customer at each service connection has agreed to installation and use of a POU treatment device and has granted access for installation, maintenance, and sampling. (11-17-05)T

viii. A plan that describes how the public water system will address any non-compliance with Subsection 450.02.d.vii. (11-17-05)T

ix. A maintenance plan that demonstrates how on-going maintenance activities will be performed and on what frequency, including: frequency of treatment media replacements, frequency of POU treatment device replacements, periodic verification that the mechanical warning device is functional, schedule of planned maintenance activities, plan of how the system will address unscheduled maintenance problems, and a plan and method of waste disposal. (11-17-05)T

x. Documentation that the system meets the current requirements for a certified operator pursuant to Section 554. (11-17-05)T

xi. A plan for on-going education and outreach to the customers of the public water system, including rental customers, on POU treatment and health effects of the contaminant(s) of concern. (11-17-05)T

xii. A plan for how the system will ensure real estate disclosures for the POU treatment system. (11-17-05)T

xiii. A statement of recognition that failure to maintain compliance with the MCL, or the failure to operate and maintain compliance with a POU treatment system as approved by the Department, may necessitate installation of centralized treatment. (11-17-05)T

e. Within thirty (30) days of installing the approved POU treatment system, the public water system shall notify the Department in writing that the POU treatment system was installed as approved by the Department. (11-17-05)T

f. Within thirty (30) days of installing the approved POU treatment system, the public water system shall submit samples from each POU treatment device to a certified laboratory for the contaminant(s) being treated by the POU treatment device. The samples shall be used to demonstrate initial compliance with the MCL. (11-17-05)T

g. The water system owner or operator must maintain records for a POU treatment system. Records shall be submitted to the Department at a frequency and in a format specified by the Department. Records to maintain shall include: (11-17-05)T

i. Requirements of Subsection 450.02.d.; (11-17-05)T

ii. All sampling performed on the POU treatment devices; (11-17-05)T

iii. Maintenance logs and schedules; (11-17-05)T

iv. Log of installed units; and (11-17-05)T

v. Contracts, lease agreements, or other legal documents with vendors and consumers. (11-17-05)T

0~~2~~3. Use of Bottled Water. 40 CFR 141.101, revised as of July 1, 1999, is herein incorporated by reference. (4-5-00)